Method and Standards for Establishing Payment Rates:
Nursing Facilities

Rates When Two Or More Nursing Facilities Merge Under One License

when a base year is established that occurs during or after the calendar year that the merger occurred.

Resident Days Used in Denominator:

The allowable historic per diem costs for the Direct Health Care cost center and food and utilities in the Indirect Health Care cost center is determined by dividing the allowable resident related expenses by the actual resident days during the cost report period. The allowable historic per diem cost for the Operating cost center and Indirect Health Care cost center less food and utilities is subject to an 85% minimum occupancy rule. The greater of the actual resident days reported for the merged facilities or days calculated at the 85% minimum occupancy will be used in the denominator of the rate calculation. If the 85% occupancy rule does not apply during the first 12 months of operation of a facility, then actual days will be used for that facility for the period that the rule does not apply. If only one of the facilities did not have the 85% occupancy rule applied then the provider will need to report the number of beds and resident days separate for that facility so that the available bed days for the merged facilities can be determined.

Real and Personal Property Fee (Property Fee) For Merged Facilities:

A combined Real and Personal Property Fee will be determined for facilities merged under one license only when a base year is established that occurs during or after the calendar year that the merger occurred. The property fee for two or more facilities that are merged under one license will be based on the day-weighted average property fee for the merged facility. The cost report used to determine the current rates would be used for the resident days for the day weighting.

For example, Facility A has a property fee of $4.00 per day and 10,000 resident days and Facility B has a property fee of $5.00 per day and 15,000 resident days. The day-weighted average property fee will be $4.60 ($4 x 10,000 days + $5 x 15,000 = $115,000/25,000 total days = $4.60). There will no longer be a value factor in the merged property fees.

Resident Assessments and Case Mix Index

The resident assessment database, based on the minimum data set (MDS), for the facilities merged under one license will be combined beginning with the first quarter after the merger. The facilities will continue to receive separate rates until after the common calendar year cost report is received for a July 1 rate. However, the case mix index will

be the same for the facilities when determining rates after the MDS data base for each facility are merged in the first quarter after the facilities are under a combined license.

Rates for Facilities Under One License If They Later Decide to Go Back To Separate Licenses

Cost Reports and Rates

If two or more facilities merge under one license and later decide to go back to individual licenses, they will file separate calendar year cost reports for the complete calendar year following the year in which they separate. Rates for each facility will be determined from base year cost report data whether that report is a combined report or not.

Real and Personal Property Fees

If two or more facilities that are merged under one license later decide to split and have individual licenses within five (5) years, the old property fees will be reassigned to the individual facilities. The additional allowance for a property fee rebasing after the property fees were combined would be added to the individual property allowances after the facilities split. The two facilities used in the combining of property fees above had a property fee of $4.60. As an example, if a property fee rebasing took place later that added $.50, the property fee will be $5.10. If Facilities A and B split before five years, the property fee for Facility A will be $4.50 ($4.00 + $.50) and the property fee for Facility B will be $5.50 ($5.00 + $.50).

If the facilities decide to split and go back to individual licenses after five years, each facility will continue to have the same property fee as determined when they merged.

Resident Assessments and Case Mix Index

If the merged facilities later decide to split into separate licenses, the MDS database will be maintained for the individual facilities beginning the first quarter after the facilities have separate licenses.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Under the Medicaid program the State of Kansas pays nursing facilities, nursing facilities for mental health, and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility (NF) reimbursement formula is divided into twelve sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Index Rate Adjustments, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, Retroactive Rate Adjustments, and Comparable Private Pay Rates.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 30-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 30-10-17.

When a non-arms length change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the

calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 30-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base year cost data submitted by the provider. The current base year is 2001.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 30-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. The allowable historic per diem cost may be adjusted by an inflation factor. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility rather than the characteristics of the facility should determine the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor and the real and personal property fee. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

Rates for Facilities Recognized as a Change of Provider

The payment rate for the first 24 months of operation shall be based on the base year historical cost data of the previous owner or provider. If base year data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the most recent calendar year submitted by the new provider.

Rates for Facilities Re-entering the Program

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the last historic cost report filed with the agency.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

3) Quarterly Case Mix Index Calculation

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.12b case mix indices developed by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

The resident listing cut off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Rate Effective Date:	Cut Off Date:
July 1	April 1
October 1	July 1
January 1	October 1
April 1	January 1

The resident listings will be mailed to providers prior to the dates the quarterly case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database. The rate for June 30, 2003 will be based on a CMI cutoff date of April 1, 2003.

4) Resident Days

The allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period used to establish the base year rate. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. The greater of the actual resident days for the cost report period used to establish the base year rate or the 85% minimum occupancy based on the number of licensed bed days during the cost report period used to establish the base year rate is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the

new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year end 2001 cost reports for rates effective June 30, 2003. The inflation will be based on the Data Resources, Inc.-WEFA, National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The inflation will be applied from the midpoint of the cost report period to December 31, 2002. No additional inflation will be applied to the rates effective July 1, 2003.

The DRI Indexes listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the Data Resources, Inc.-WEFA, National Skilled Nursing Facility Total Market Basket Index (DRI Index). The real and personal property fees in effect June 1, 2003 will have inflation applied for the period from July 1, 2002 to June 30, 2003.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the base year historic cost reports in the database from all active nursing facility providers. The salary information is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than twelve months. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an

administrator of a 15-bed or less facility. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the property fees in effect June 1, 2003, with inflation applied.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care and Direct Health Care. The schedule includes the base year cost data from all active nursing facility providers. Projected cost reports are excluded from the database.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines will be adjusted for historical and forecasted inflation, where appropriate. This will bring the costs reported by the providers to a common point in time for comparisons. The historic inflation will be based on the DRI Index for the cost center limits effective June 30, 2003. This historic inflation factor will adjust costs from the midpoint of each providers cost report period to December 31, 2002 for the Schedule B processing.